

Bureau of Health Care Quality and Compliance

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3935ASC | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/05/2010 |
| NAME OF PROVIDER OR SUPPLIER ELITE ENDOSCOPY | | STREET ADDRESS, CITY, STATE, ZIP CODE 7150 SMOKE RANCH ROAD, SUITE 150 LAS VEGAS, NV 89128 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| A 00 | INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a State Licensure focused survey conducted in your facility on 3/5/10, in accordance with Nevada Administrative Code, Chapter 449, Surgical Centers for Ambulatory Patients. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified: | A 00 | | |
| A112 SS=F | NAC 449.9855 PERSONNEL 2. Each employee of the center must: (a) Have a skin test for tuberculosis in accordance with NAC 441A.375. A record of each test must be maintained at the center. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure 5 of 5 employees met the requirements of NAC 441A.375 concerning tuberculosis (TB). (Employees #1, #2, #3, #4 and #5). 1. The files for Employees #2 and #5 did not contain a second-step TB skin test. 2. The files for Employees #2 and #3 did not meet the annual one-step TB skin test requirements in accordance with NAC441.A.375. 3. The files for Employee #1 did not contain the | A112 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

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| A112 | Continued From page 1 results of a positive skin test or a statment froma physician that the employee had tested positive for TB and did not have a two step TB test on file. Severity: 2 Scope: 3 | A112 | | | |

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